School Corporation Medicaid Billing

HP Provider Relations
April 2011

Agenda

- Definitions
- Provider Enrollment
- Member Eligibility
- Treatment Plans
- Covered Services
- Billing Guidelines
- Service-specific Guidelines
- National Correct Coding Initiative (NCCI)
- Helpful Tools
- Questions

Definitions

- Individuals with Disabilities Education Act (IDEA) – federal law assures a free and appropriate public education (FAPE) and related services designed to meet the unique needs of children with disabilities
- Individualized Education Program (IEP) – written document developed by a case conference committee that describes how a student will access the general curriculum, special education, and related services
- Individualized Family Service Plan (IFSP) – written plan for providing early intervention services to an eligible child under age 3
- Supervision – supervision of a mid-level practitioner (in some cases *on-site* supervision is required, meaning supervisor is in the *same building* when services are rendered)
- Medicaid-qualified Provider – any entity or person who meets state and federal Medicaid provider qualifications

Provider Enrollment

State law (*IC 12-15-1-16*) requires school corporations (includes charters) to enroll as Medicaid providers (*Note: Not required to bill*)

Note: The school's practitioner (for example, therapist) is not required to be enrolled as a Medicaid provider, but must meet Medicaid-qualified provider criteria for the services billed by the school corporation

– Obtain a National Provider Identifier (NPI)
  • For details, refer to your Medicaid Billing Tool Kit, Section 2.3.2

– Complete the Provider Enrollment Application available at indianamedicaid.com > Become a Provider > Enroll as a Provider

– New provider application can be completed on the Web directly or by paper application

– Mail the application (including your corporation's NPI) to:

HP Provider Enrollment

P.O. Box 7263

Indianapolis, IN 46207-7263

Note: Only public school corporations and charters recognized by the Indiana Department of Education, not special education cooperatives, may be enrolled under the "School Corp" Medicaid Provider Type

Member Eligibility

For services to be reimbursed, students must:

– Be at least 3 but less than 22 years old

– Be eligible for services under IDEA

– Be Medicaid-eligible on the date of service

– Have an IEP/IFSP listing the Medicaid-covered medical or health-related service(s)

– Receive covered IEP/IFSP services provided by an employee or contractor of the school corporation that meets Medicaid-qualified provider criteria for the service delivered

Treatment Plans

- A treatment plan, or plan of care, is required for all Medicaid-covered IEP/IFSP services and must be reviewed every 60 days
- The IEP or IFSP may qualify as the treatment plan if:
  - It meets the plan of care criteria specified in the “plan of care” descriptions in each service-specific section of the Medicaid Billing Tool Kit
  - It includes the amount, frequency, duration, and goals of the services to be provided

Covered Services

- Medicaid-covered IEP services include:
  - Audiology services
  - Occupational therapy services
  - Physical therapy services
  - Psychological/behavioral services
  - Speech-language pathology services
  - Nursing services provided by a registered nurse (RN)
  - Special education transportation services
- School corporations may bill Medicaid only for:
  - Health-related diagnostic and treatment services **in** an eligible student's IEP/IFSP, **or**
  - A health-related diagnostic service **required to develop** the IEP/IFSP of a Medicaid-enrolled student (such as an evaluation)

Note: Medicaid coverage may not be available for all health-related services in a student's IEP/IFSP

Covered Services

Medicaid covers medically necessary services that:

– Are individualized, specific, and consistent with symptoms or confirmed diagnoses of the illness or injury under treatment, and not in excess of the needs of the Medicaid-enrolled student

– Are not experimental or investigational

– Are reflective of the level of services that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available

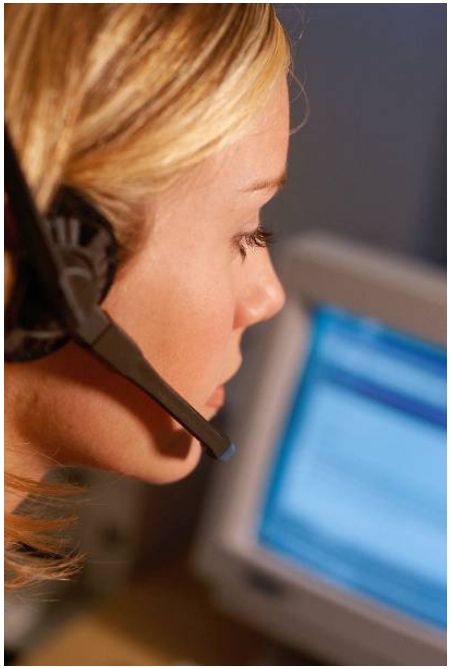
– Are furnished in a manner not primarily intended for the convenience of the student, his or her caretaker, or the provider

– Do not duplicate a service performed by another provider

General Billing Guidelines for all IEP Services

When billing any IEP service to Medicaid:

– Obtain a signed release/consent from the parent (s) or guardian to verify a student's eligibility and bill Medicaid
  - The signed consent must be obtained with each IEP
– Submit charges on the appropriate standardized CMS-1500 claim form or via approved electronic transaction format
– Be aware that claim filing limits will apply to claims submitted
– Bill with the applicable national, standardized procedure code, any applicable modifier(s) and corresponding unit(s) of service

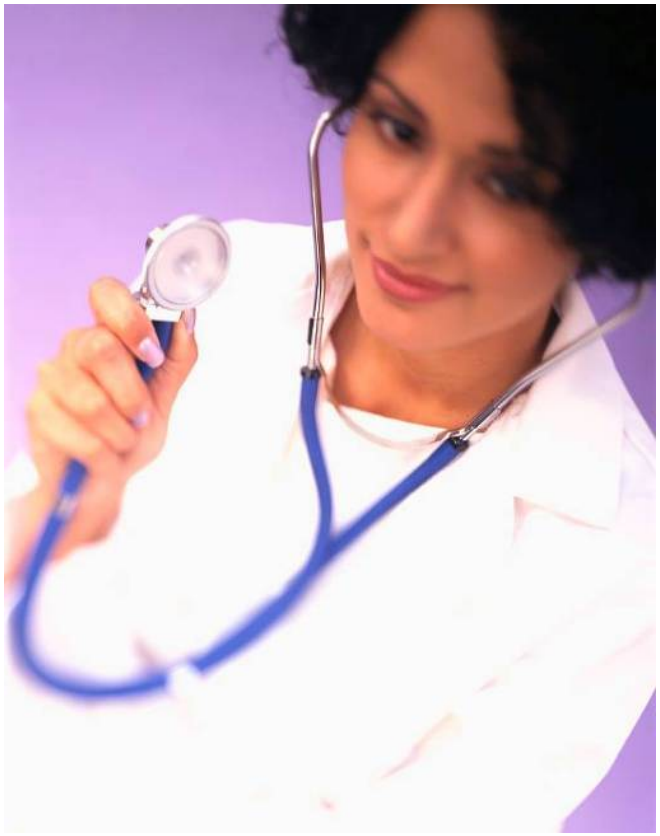


Explain

Service-Specific Billing Guidelines

Service-Specific Billing Guidelines

- Audiology
- Occupational therapy
- Physical therapy
- Psychological/behavioral
- Speech-language pathology
- Nursing services provided by an RN
- Special education transportation



Audiology

Provider qualifications

Medicaid-qualified providers of audiology services are one of the following:

– Licensed, Medicaid-qualified audiologist, with the following:
  - American Speech-language Hearing Association (ASHA) certification or successful completion or in process of completing supervised clinical experience
  - At least nine months' full-time supervised experience after master's or doctorate completion
  - Successful completion of national qualifying exam

– Otolaryngologist
  - Who meets all other federal and state qualifications and licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 3.2

Audiology

Service requirements

- Requires physician's written order and Medicaid Medical Clearance and Audiometric Test Form
- Student's history part of form must be completed by a Medicaid-qualified provider
- Referring physician must complete form no earlier than six months prior to hearing aid provision
- Maintain form for audit purposes
- Children ages 14 and under must be examined by an otolaryngologist
- Initial assessment limited to one every three years per student, except where there is a documented disease

Audiology

Reimbursement limitations

- Audiology procedures, such as hearing and screening tests, cannot be fragmented and billed separately
- A screening test indicating the need for additional medical examination is not separately reimbursed by Medicaid
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 3: Audiological Services
  - Appendix E, Table 3, Billing Procedure Codes
  - Appendix H, Medicaid Medical Clearance and Audiometric Test Form

Occupational Therapy

Provider qualifications

Medicaid-qualified occupational therapist (OT) providers are one of the following:

– Registered occupational therapist

– Certified occupational therapy assistant acting within his or her scope of practice under the direct *on-site* supervision of the registered OT

- Who meets all other federal and state qualifications and licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 6.2

Occupational Therapy

Service requirements

- A physician's or other qualified "healing arts" practitioner's referral is required
- Services, except evaluations, may be provided by an OT or certified occupational therapist assistant (COTA)
- **Evaluations** must by performed by a registered occupational therapist, not an occupational therapist assistant
- Service documentation must include the student's name, diagnostic testing and assessment, and a written report identifying needs

Occupational Therapy

Reimbursement limitations

- One evaluation and one reevaluation per student, per school year
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 6: Occupational Therapy Services
  - Appendix E, Table 2, Billing Procedure Codes

Physical Therapy

Provider qualifications

Medicaid-qualified physical therapist (PT) providers are one of the following:

– Licensed physical therapist

– Certified therapist assistant under direct, but not necessarily on-site, supervision of a licensed physical therapist

- Who meets federal and state qualifications as well as licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 4.2

Physical Therapy

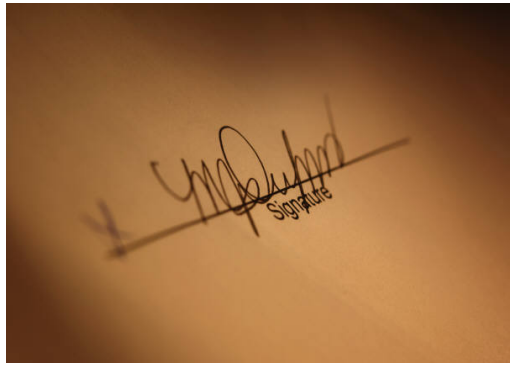
Service requirements

- A physician's or other qualified "healing arts" practitioner's referral is required
- Services, except evaluations, may be provided by a PT or physical therapist assistant (PTA)
- **Evaluations** must by performed by a registered physical therapist, not a physical therapist assistant
- PT-related services may not be billed separately from therapy; examples include:
  - Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment
  - Transporting patients, records, equipment, and supplies
  - Assembling and disassembling equipment

Physical Therapy

Reimbursement limitations

- One physical therapy evaluation and one reevaluation per eligible student, per school year
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 4: Physical Therapy Services
  - Appendix E, Table 2, Billing Procedure Codes



Psychological/Behavioral

Provider qualifications

– Medicaid-qualified Behavioral Service providers are one of the following:
  - Physician (MD or DO)
  - Health service provider in psychology (HSPP)

– The following mid-level practitioners may also provide services *under the direction of a physician or HSPP*:
  - Licensed psychologist
  - Licensed independent practice school psychologist
  - Licensed clinical social worker
  - Licensed marital and family therapist
  - Licensed mental health counselor
  - A person holding a master's degree in social work, marital and family therapy, or mental health counseling

Psychological/Behavioral

Mid-level practitioners

– An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing
  - Who meets federal and state qualifications as well as licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 7.2

Psychological/Behavioral

Psych and neuropsych testing practitioners

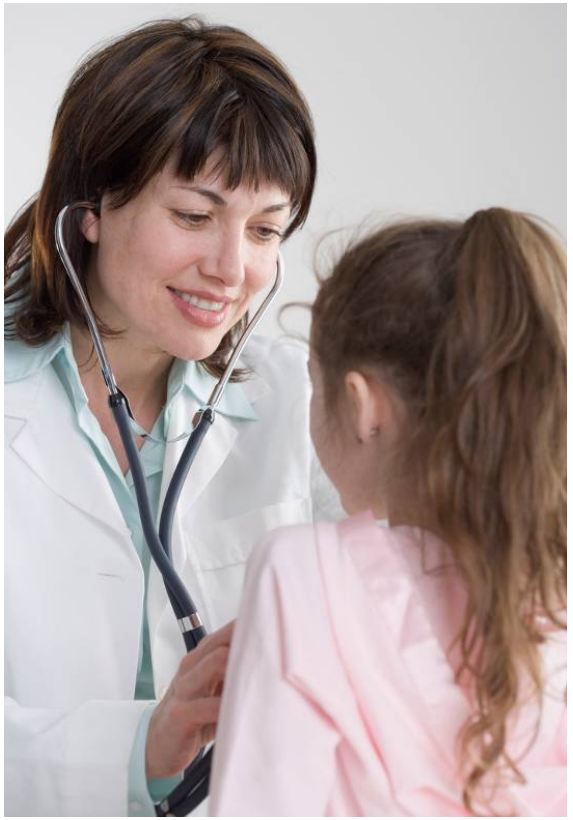
Medicaid reimburses for neuropsychological and psychological testing when provided by one of the following:

- Physician
- HSPP
- One of the following practitioners working under direct supervision of a physician or HSPP:
  - A licensed psychologist
  - A licensed independent practice school psychologist
  - A person holding a master's degree in a mental health field and one of the following:
    - A certified specialist in psychometry (CSP)
    - Two thousand hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed
  - Who meets federal and state qualifications as well as licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 7.2

Psychological/Behavioral

Service requirements

- A physician or HSPP referral is required
- The physician or HSPP must see the student at initial visit, or review and sign off on the documentation of the initial visit with a mid-level practitioner, prior to initiation of services and within seven days of the initial visit/intake
- In addition, the physician or HSPP must see the student or review the medical records and certify medical necessity (sign documentation) at least every 90 days



Psychological/Behavioral

Reimbursement limitations

– For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 7: Behavioral Services
  - Appendix E, Table 1, Billing Procedure Codes

Note: Be aware of restrictions (certain procedures may only be billed by a physician or HSPP)

Speech-Language Pathology

Provider qualifications

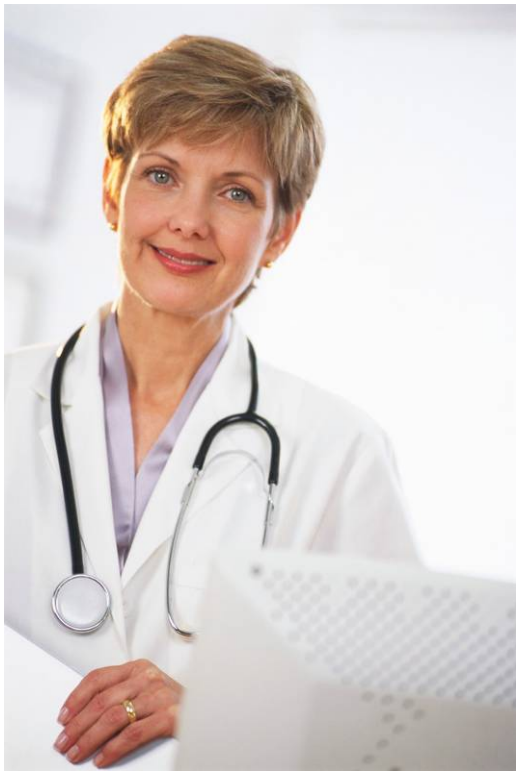
Medicaid-qualified providers of Speech services are one of the following:

- A licensed speech-language pathologist who meets one of the following requirements:
  - Has the American Speech-Language Hearing Association (ASHA) certificate of clinical competence ("CCCs")
  - Has completed the academic program and is acquiring supervised work experience to qualify for the certificate
  - Has completed equivalent educational requirements and work experience necessary for the certificate
- A registered speech-language pathology aide, subject to *880 IAC 1-2*, under direct *on-site* supervision of a licensed speech-language pathologist
  - Who meets federal and state qualifications as well as licensure and practice standards in the School Corporation Medicaid Billing Tool Kit Chapter 5.2

Speech-Language Pathology

Service requirements

- A physician's or other qualified "healing arts" practitioner's referral is required
- Services, except evaluations, may be performed by a speech-language pathologist (SLP) or SLP support personnel
- **Evaluations** must be conducted by a licensed SLP
- Service documentation must include the student's name, diagnostic testing and assessment, and a written report identifying needs



Speech-Language Pathology

Reimbursement limitations

- One speech-language pathology evaluation and one reevaluation per student, per school year
- Group therapy is covered in conjunction with, not in addition to, regular individual treatment; Medicaid will not pay for group therapy as the only or primary means of treatment
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 5: Speech-Language Pathology Services
  - Appendix E, Table 3, Billing Procedure Codes

IEP Nursing

Provider qualifications

A Medicaid-qualified provider of IEP nursing services must be a:

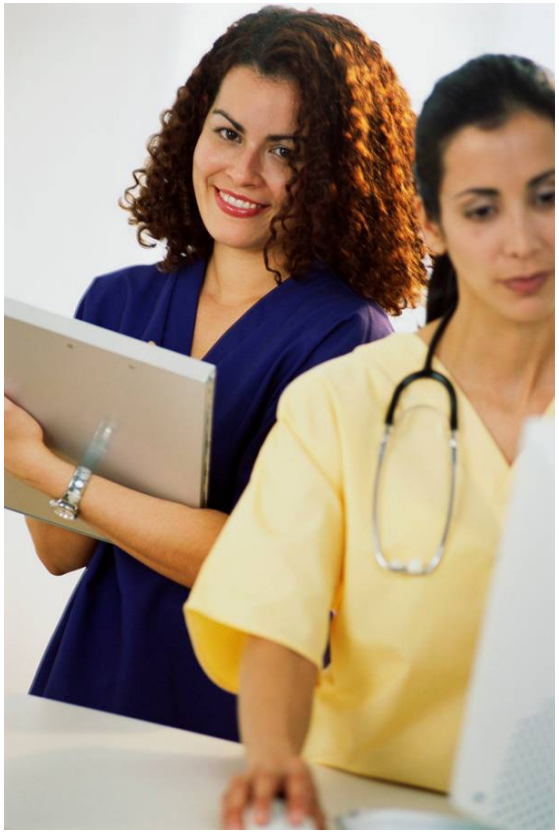
– Licensed registered nurse (RN)

- Who is employed by the local education agency, **or**
- Working under a contract between the local education agency and one of the following:
  - Nurse/individual service provider
  - Company that employs the nurse (for example, a nurse registry or home health agency)
- Who meets all other federal and state qualifications and licensure and practice standards described in the School Corporation Medicaid Billing Tool Kit Chapter 8.2

IEP Nursing

Service requirements

- Requires physician's written order
- Must be medically necessary and provided in a school setting (including field trip site, school bus, or other as required by IEP)
- Must be provided in accordance with written plan of care (see Tool Kit section 8.4.)
- Must be provided by the RN (cannot be delegated)



IEP Nursing

Reimbursement limitations

- School corporations must bill for the appropriate start and stop times of services
  - The place of service (POS) must be indicated for services provided off-site (refer to Tool Kit Section 2.5.9. for POS codes)
- Aggregate total IEP nursing time is billed per day, using the appropriate Current Procedural Terminology (CPT®) code and modifier to describe the service, in conjunction with the IEP-related modifier "TM" and the appropriate number of units of service (15-minute increments)
  - Partial units of service must be rounded to the nearest whole unit
  - A minimum of eight minutes of service must be provided to bill for one unit
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 8: IEP Nursing Services
  - Appendix E, Table 5, Billing Procedure Codes
  - Appendix F, pages *F10* and *F11* for sample documentation form and billable service examples

Special Education Transportation

Provider qualifications

Medicaid-qualified providers of special education transportation services are:

– The school corporation's employee or contractor who meets the standards for driver personnel
  - Who meets all other qualifications and standards described in the School Corporation Medicaid Billing Tool Kit Chapter 9.2 and applicable rules (see Tool Kit Appendix C)

Note: In addition to holding a commercial driver's license, school bus drivers must comply with State safety experience, education, and certification requirements. School corporations must comply with statutory requirements on public liability and property damage insurance covering the operation of school bus equipment. Vehicles used for Medicaid transportation services must comply with applicable school bus standards. (See Tool Kit Appendix C, pages C41 – C60).

Special Education Transportation

Service requirements

- Services must (1) meet a health-related, including behavioral, need that is documented in the student's IEP and (2) be provided on a day when the student receives another Medicaid-covered IEP service
- Must involve a trip:
  - Between home and school, **or**
  - Between school or home and an off-site Medicaid service provider
- Additional payment is available for an attendant, subject to the limitations in *405 IAC 5-30-8(1) - (2)*, provided the IEP includes the need for an attendant and all other Medicaid requirements are met

Special Education Transportation

Service requirements

- Except as described below, services must be provided in a vehicle that:
  - Meets specifications in *575 IAC Rule 5* "Vehicles for Transporting the Handicapped"
  - Is appropriate to accommodate the student's disability
- Services may be provided in any school bus that meets the definitions in *575 IAC 1-1-1 (a) - (h)*, if:
  - The child resides in an area that does not have school bus transportation but has a medical need for transportation that is noted in the IEP, **or**
  - The transportation is from the school to a community-based Medicaid provider such as a mental health center for purposes of receiving a Medicaid-covered service listed in the child's IEP

Special Education Transportation

Reimbursement limitations

- Transportation must be the least expensive type to meet the medical needs of the student (who must be present in the vehicle), and drivers are expected to take the shortest, most efficient route to and from the destination
- Services are not covered when provided by a member of the child's family if that person is not an employee of the school corporation
  - No reimbursement is available for tolls, parking fees, or transfer of durable medical equipment (DME) between the student's residence and the place of DME storage
- For further details, please consult your School Corporation Medicaid Billing Tool Kit
  - Chapter 10: Special Education Transportation Services
  - Appendix E, Table 6, Billing Procedure Codes
  - Appendix F, Pages *F8* and *F9* for sample documentation (Trip Log) forms


Understand
National Correct Coding Initiative

National Correct Coding Initiative

What is it?

– In the 1990s, the Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment

– NCCI has been in place for many years and most billers are familiar with the editing methodologies used with Medicare

– Based on input from a variety of sources:

- American Medical Association (AMA) Current Procedural Terminology (CPT®) guidelines
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practices
- Review of current coding practices

National Correct Coding Initiative

- The recent healthcare legislation passed into law (H.R. 3962), requires that Medicaid programs incorporate compatible methodologies of the NCCI into their claims processing system
- Section 6507 mandates that NCCI methodologies must be effective for claims filed on or after October 1, 2010
- Initial editing will encompass three basic coding concepts:
  - NCCI Column I and Column II
  - Mutually Exclusive (ME) Edits
  - Medically Unlikely Edits (MUE)

Column I and Column II

Define

- Column I/ Column II Procedures should be reported with the most comprehensive CPT code that describes the services performed
- Physicians must not unbundle or report multiple Healthcare Common Procedure Coding System (HCPCS)/CPT codes when a single comprehensive HCPCS/CPT code describes the services that were furnished

Mutually Exclusive Edits

Define

– Procedure codes that cannot be reported together because they are mutually exclusive of each other

– Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter

– Two or more procedures performed during the same patient encounter on the same date of service and same billing provider that are not normally performed together

Medically Unlikely Edits

Define

- HCPCS/CPTs have a defined unit of service for reporting purposes
- Providers that bill units of service for a HCPCS/CPT code using a criteria that differs from the code's defined unit of service will experience a denial
- MUE editing is based on the units of service allowed on the claim, not the units of service billed

National Correct Coding Initiative

– The NCCI Policy Manual is located at http://www.cms.gov/NationalCorrectCodInitEd/

National Correct Coding Initiative

How does it work?

- NCCI editing is applied to claims reporting:
  - Same date of service
  - Same member
  - Same billing provider NPI
- *BT201036* defines these edits including:
  - New explanation of benefits (EOB) numbers
  - EOB descriptions
  - Purpose of EOBs

Use of Modifiers

What is correct?

- Modifiers may be appended to HCPCS/CPT codes only when clinical circumstances justify the use of the modifier
- A modifier should not be appended to a HCPCS/CPT code solely to bypass NCCI editing
- The use of modifiers affects the accuracy of:
  - Claims billing
  - Reimbursement
  - NCCI editing
  - Clarification of procedures
  - Special circumstances
- NCCI bulletin *BT201036* refers providers to the CMS Web site for reporting of codes
  - This guidance indicates that when two separate and distinct therapy services are provided to the same patient on the same day, the subsequent separate and distinct service should be billed with the 59 modifier
    - Use the modifier in conjunction with only one of the two codes

Administrative Review

Requirements

- Administrative review must be requested within seven days of notification of claims payment or denial
  - Used when there are unusual circumstances in which a provider believes the claim was coded correctly and would like reconsideration of the NCCI editing
- Complete an Indiana Health Coverage Programs (IHCP) Inquiry form or write a letter stating:
  - Reason for disagreement
  - Denial or amount of reimbursement
  - Clearly note “Administrative Review” on the form or letter
  - Attach all pertinent documentation
  - Add “Attention To: Health Care Administrative Review Specialist”
- The IHCP Inquiry form can be obtained from the Indiana Medicaid Web site in the Forms section at www.indianamedicaid.com

Administrative Review

Address

– Send forms or letters to:

- Attn: Healthcare Administrative Review Specialist
  Written Correspondence
  P. O. Box 7263
  Indianapolis, IN 46207-7263

Concerns about Specific NCCI Edits

For NCCI information only

– Submit comments in writing to:
  - National Correct Coding Initiative
    Correct Coding Solutions, LLC
    P.O. Box 907
    Carmel, IN 46082-0907

– Send to the attention of Niles R. Rosen, MD, Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

– Send questions regarding NCCI table edits only; do not send claims questions or claim appeals


Find Help
Resources Available

Helpful Tools

- School Corporation Medicaid Billing Tool Kit available at http://www.doe.in.gov/exceptional/speced/docs/
- School Corporation Medicaid Billing Guide online at http://www.doe.in.gov/exceptional/speced/docs/
- Medicaid Web site at www.indianamedicaid.com
- Medicaid (IHCP) Provider Manual online at www.indianamedicaid.com on the Manuals page
- HP Customer Assistance
  - 1-800-577-1278 toll-free
  - (317) 655-3240 in the Indianapolis local area
- HP Written Correspondence
  - P.O. Box 7263

    Indianapolis, IN 46207-7263
- Provider Relations Field Consultants
  - View a current territory map and contact information at www.indianamedicaid.com

Q&A